

Family Acceptance and Self-Esteem Moderate the Relationship between Sexual Minority Status and Psychological Distress among Men who have Sex with Men

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ABSTRACT

Despite the stressful psychological conditions and social marginalization that men who have sex with men (MSM) experience, surprisingly, some men who identify as sexual minorities report little or no psychological distress. This study analysed the possible moderating effect of family acceptance and self-esteem in the relationship between sexual orientation and mental health. The study sample consisted of 287 MSM aged 18 to 40 years, recruited through online platforms, LGBTQ+ community organizations, and social networks. Indicators of emotional and behavioral difficulties, symptoms of depression, suicidal behavior, well-being, family acceptance, and self-esteem were assessed. Zero-order correlations of all study variables were tested with the study's dependent variable. Mediating analysis revealed that internalized homonegativity and rejection sensitivity were positively associated with depressive symptoms for those reporting less family acceptance and low self-esteem, but they were not associated for those reporting more family acceptance. Findings further suggest that family acceptance and high self-esteem may be important resilience factors that can shield against psychosocial distress among sexual minorities. Findings of this study highlight the importance of expressing family acceptance and support, which may directly impact self-esteem and well-being and serve as a buffer against minority stress.

Keywords: *Family Acceptance; Self-Esteem; Sexual Minority; Psychological Distress*

INTRODUCTION

The term "men who have sex with men" (MSM) refers to a broad category that includes people of different sexual orientations, such as heterosexual, gay, and bisexual men. Due to their status as sexual minorities, MSM frequently experience psychosocial difficulties. A serious public health issue that is impacted by sexual minority status is psychological distress among men who have sex with other men (Meyer, 2023). Mental health issues are more common in men who have sex with men (MSM) than in heterosexuals (Cochran et al, 2019). Meyer (2023) proposed that these mental health disparities are due, in part, to the stress that sexual minorities experience because of their socially marginalized status.

Meyer (2023) specifically identified a number of minority stressors that MSM people are susceptible to, such as expectation of rejection due to sexual orientation (rejection sensitivity), internalizing negative societal attitudes about nonheterosexuality (internalized homonegativity), and discrimination based on sexual orientation. When compared to their heterosexual peers, these aspects of minority stress are linked to a number of detrimental outcomes, such as anxiety, depression, and suicidal thoughts, as well as low life satisfaction and a higher likelihood of drug addiction (Feinstein et al., 2022).

There are protective variables that could mitigate the detrimental impacts of being a sexual minority, according to Doty et al. (2020). Self-esteem and family acceptance are two possible modifiers that are important in determining mental health outcomes (Doty et al., 2020). The extent to which a person's family accepts, validates, and supports their sexual identity is known as family acceptance. Given that many MSM people have tense connections with their family members, it is especially crucial to take into account how family interactions affect their wellbeing. According to Pearson and Wilkinson (2023), these family characteristics include a higher number of issues with parents, a lower level of family connection, a lower level of parental support, a lower level of closeness with parents, and a lower level of family support. MSM people report greater rates of abuse from family members than do heterosexual people (Saewyc et al., 2020), and parents frequently react negatively when a child discloses a minority sexual orientation (D'Augelli et al., 2022). Furthermore, it has been shown that a number of family relationship factors partially explain health disparities related to sexual orientation, and that sexual minorities report lower levels of parental support than heterosexual people (Eisenberg & Resnick, 2019; Russell et al., 2022).

Despite the paucity of research on family ties and MSM well-being, what is known indicates that supportive family interactions are a factor in their well-being (Russell et al., 2022). According to research, MSM may benefit greatly from family acceptance as a buffer against psychological anguish. MSM people may be shielded from mental health issues by supportive family interactions (Goldfried & Goldfried, 2021). For example, higher well-being is linked to having a positive relationship with one's parents, feeling more supported and accepted by the family, feeling more cared for by the family, and feeling more accepted by the parents (Ryan et al., 2020). However, among MSM youth, increased depressive symptoms are linked to poorer parent-child connections, parental rejection of one's sexual orientation, and fear of verbal and/or physical violence at home (D'Augelli et al., 2022). Negative outcomes, such as depression symptoms, suicidal thoughts and attempts, illicit substance usage, substance-related issues, and unprotected sex with a casual partner, are also linked to experiences of family rejection among MSM adults (Ryan et al., 2020). Parental support is generally linked to better well-being in teenagers and young adults, indicating that parental relationships remain crucial for wellbeing throughout adulthood.

The association between psychological discomfort and sexual minority stress can be moderated by self-esteem (Szymanski, 2019). The term "self-esteem" describes a person's general feeling of regard and value for themselves. By encouraging resilience and adaptive coping strategies, high self-esteem helps MSM manage minority stress more skillfully (Shilo & Savaya, 2021). Negative societal perceptions about sexual minorities are less likely to be internalized by those who have good self-esteem, hence lowering the chance of psychological distress by bolstering a person's confidence in their capacity to handle challenges. Better mental health results, result from MSM who have higher self-esteem because they are more likely to incorporate their sexual identity into their total self-concept. On the other hand, low self-esteem may increase the detrimental effects of sexual minority stress, increasing a person's susceptibility to psychological distress such as anxiety and depression.

Self-esteem and family acceptability interact in a very important way. By confirming one's identity, family support can increase self-esteem and lessen vulnerability to psychological discomfort. To put it another way, self-esteem may be indirectly bolstered by familial acceptance, forming a protective circuit that lessens the effects of sexual minority stress (Eisenberg & Resnick, 2019). On the other hand, MSM who have low self-esteem and little familial support are more vulnerable to negative mental health consequences.

The majority of research on mental health, self-esteem, and social support in MSM groups has been on how social support directly affects mental health outcomes. Though research has shown this effect in non-MSM populations, it has also been hypothesized that social support may buffer (i.e., attenuate) the correlations between stress and distress (Davidson & Demaray, 2017). Few research has looked at this idea in MSM samples. Szymanski (2019) discovered that the relationships between heterosexist events (discrimination, rejection, and harassment) and psychological suffering among gay and bisexual males were not mitigated by general social support. According to Hershberger and D'Augelli (2025), family support significantly decreased the correlation between victimization and psychological symptoms in gay youth. This meant that youth who experienced low levels of victimisation—such as verbal remarks—benefited from high levels of support, but not those who experienced moderate levels of victimisation—such as property destruction—or high levels of victimisation—such as physical attacks.

There are obviously a lot of unanswered questions regarding the possible stress-reduction benefits of MSM persons' self-esteem and familial acceptance. In particular, it is yet unknown whether familial acceptance and self-esteem mediate relationships between other aspects of minority stress (such as internalized homonegativity and rejection sensitivity) and their effects on mental health because prior research has concentrated on victimisation. Furthermore, it's critical to look at both more general family support and features of family ties that are explicitly connected to sexual orientation, such as parental acceptance of one's sexual orientation.

This idea has been supported by a recent study that showed that greater levels of support from friends and family members related to sexuality (i.e., support for sexuality-related issues only) were associated with less emotional distress and protected against the detrimental effects of sexuality stress on emotional distress (Doty et al., 2020).

By investigating the degree to which self-esteem and parental approval mediate relationships between aspects of minority stress and depressive symptoms in a sample of males who have sex with men, the current study aimed to build on earlier findings. This study looked at a number of minority stress factors, such as rejection sensitivity, internalized homonegativity, and discrimination, in line with minority stress theory (Meyer, 2023). According to the study's hypothesis, minority stress would be linked to depressive symptoms for people who reported lower levels of family acceptance and self-esteem but not for people who reported higher levels of these factors. This is because family acceptance and self-esteem were thought to moderate associations between all three dimensions of minority stress and depressive symptoms.

The need to identify the moderating factors in the relationship between sexual minority status and psychological distress stems from the risk to mental health, which is partly caused by the stress that sexual minorities endure as a result of their social marginalisation (Olaseni & Adewoye, 2023). This is because some males who identify as sexual minorities report little to no psychological suffering, even if they face social marginalisation and harsh psychological situations as a result of having sex with men (MSM). This implies that there may be mitigating influences in the association between psychological distress and sexual minority status. The potential moderating effects of self-esteem and family acceptance on the association between sexual orientation and mental health were examined in this study. This study specifically looked at how much self-esteem and family acceptance of one's sexual orientation influenced the relationships between aspects of minority stress and psychological suffering.

Specifically, this study aimed to answer the following research question:

- *How can family acceptance and self-esteem moderate the relationship between Sexual Minority Status and Psychological Distress among Men who have Sex with Men?*

Hypothesis

- *Family acceptance and self-esteem will moderate the relationship between Sexual Minority Status and Psychological Distress among Men who have Sex*

METHODS

Research Design

To investigate the moderating effects of self-esteem and family acceptance on the association between psychological distress and sexual minority status among men who have sex with men (MSM), this study utilised a cross-sectional correlational methodology. A correlational design was selected to explore associations among variables at a single point in time, enabling the identification of potential moderators of psychological outcomes.

Participants and Procedure

The study sample consisted of MSM aged 18 years and above, recruited through online platforms, LGBTQ+ community organizations, and social networks. Inclusion criteria required participants to self-identify as MSM and to have disclosed sexual orientation to at least one family member. Exclusion criteria included cognitive impairments or the inability to provide informed consent. A total of 300 participants completed the survey, representing diverse age groups, educational levels, and socioeconomic backgrounds. A total of 13 individuals, due to one reason or the other were unable to complete the questionnaires, resulting in a final sample of 287. Confidentiality and anonymity were emphasized to ensure honest reporting of sensitive information. It took about twenty to twenty-five minutes to finish the survey. Ethical approval was acquired from the appropriate institutional review board prior to data collection.

Measures

Discrimination. The level of discrimination was assessed using the MSM-inclusive version of the Heterosexist Harassment, Rejection, and Discrimination Scale (Szymanski, 2019). The 14-item measure gauges how frequently people report experiencing heterosexist harassment, rejection, and discrimination over the past 12 months. For example, participants were asked, "In the past year, how many times have you been verbally insulted because you are a gay/lesbian person?" A 6-point Likert-type scale was used to rate each item, ranging from 1 (*the event has never occurred to you*) to 6 (*the event occur frequently [more than 70% of the time]*), and total scores were computed by calculating the mean for the 14 items. Higher ratings indicated more discrimination throughout the previous 12 months. The total scores ranged from 1 to 6. Lesbians and gay/bisexual males have been found to have excellent internal consistency and good convergent and discriminant validity (Szymanski, 2019). The current sample's alpha was .94.

Rejection Sensitivity. Rejection sensitivity was measured using a modified Gay-Related Rejection Sensitivity Scale (Pachankis et al., 2008). Twelve scenarios were shown to the participants, and they were asked to rate the

chance that the circumstance would have happened due to their sexual orientation as well as how worried or frightened they would be if it did.

Internalized Homonegativity. Internalized homonegativity was measured using the internalized homonegativity/binegativity subscale from the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Fassinger, 2003). Five of the 27 items in the LGBIS measure a person's negative attitudes regarding their own minority sexual orientation, among other aspects of LGB identification. For instance, "If I could, I would prefer to be straight" and "Heterosexual lifestyles are more fulfilling than homosexual lifestyles." Each question was rated on a 7-point Likert-type scale, with 1 denoting "strongly disagree" and 7 denoting "strongly agree." The mean of the five items—some of which were reverse-scored—was used to calculate the overall scores. Higher scores indicate greater internalized homonegativity; total scores range from 1 to 7. There have been reports of good internal consistency (Balsam & Mohr, 2007), and the alpha for the current sample was .81.

Depressive Symptoms. Depression symptoms were measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). Six items on the CES-D measure symptoms of depression. After being shown symptoms (such as "I was bothered by things that usually don't bother me"), participants were asked to rate how frequently they had such feelings over the course of the previous week. Each item was rated on a 4-point Likert-type scale, with 0 denoting "rarely" or "never" and 3 denoting "most" or "always." The 21 items were summed (some items were reverse scored) to determine the overall scores. Total scores could range from 0 to 60, of which higher scores signalled greater depressive symptoms. Discriminant validity, convergent as well as good internal consistency were all reported (Radloff, 1977), and the alpha in the current sample was .94.

Parental Acceptance. Parents' acceptance of a child's sexual orientation was measured using two questions developed by Pachankis et al. (2008). Inquiries were made about whether participants had told their father (or closest male guardian) and mother (or closest female guardian) about their minority sexual orientation. The majority of participants (85%) said they told their mother and father about their sexual orientation, while only 12% and 3%, respectively, had told their mother and father. We asked, "How tolerant is she [or he] toward your sexual orientation currently?" to those who had told their parents they were gay. Each item was answered on a 7-point Likert-type scale ranging from 1 (totally accepting and tolerant) to 7 (absolutely antagonistic and rejecting). In accordance with Pachankis et al. (2008), the mean for maternal and paternal acceptance, .78 for those who had told their mother and father, was used to calculate parental acceptance scores. Parental attitudes were more accepting when scores were lower, and less accepting when scores were higher.

Self-Esteem. The Rosenberg Self-Esteem Scale (RSES), a popular 10-item measure of overall self-worth, was used to measure self-esteem; higher scores indicate higher self-esteem. Each question was rated on a 5-point Likert-type scale, with 1 denoting "strongly disagree" and 5 denoting "strongly agree." The mean of the four items was used to determine the subscale scores. Stronger ratings indicated stronger self-esteem; total scores varied from 1 to 5. The current sample's alpha was .94.

Data Analysis

Data were analyzed using SPSS v27. Preliminary analyses included descriptive statistics and reliability testing for all scales (Cronbach's $\alpha > 0.70$). Pearson correlation analyses examined associations between sexual minority status, family acceptance, self-esteem, and psychological distress. To test the moderating effects of family acceptance and self-esteem, hierarchical multiple regression analyses were conducted. Interaction terms were created by centering the moderator variables and multiplying them by sexual minority stress scores. Significance was set at $p < 0.05$.

RESULTS

The zero-order correlations, means, standard deviations, and ranges of the primary study variables are shown in Table 1. Significant associations were recorded among all three dimensions of minority stress (discrimination, internalized homonegativity, and rejection sensitivity), such that participants who reported a high score on one variable also tended to report relatively high scores on the other variables. Depressive symptoms were also substantially correlated with higher ratings on each minority stress factor. Lower minority stress (as measured by all three factors), less depressive symptoms, and more overall family support were all substantially correlated with more welcoming parental attitudes. Less rejection and discrimination sensitivity (but not internalized homonegativity) and fewer depressive symptoms were also substantially correlated with higher family support.

Moderating Effect of Family Acceptance

Three hierarchical regression models (one for each minority stress factor) were performed to investigate if parental acceptance affected the relationships between the minority stress dimensions and depressed symptoms. The interaction term was put after the main impacts of the predictor variables in each analysis. To minimize

multicollinearity, all predictor variables were mean centered before calculating interaction terms (Aiken & West, 1991). The reader is advised to keep in mind that the data are cross-sectional, which precludes examination of temporal relationships, even if depressive symptoms are treated as the end variable in these analyses, in accordance with current theory and research. Table 2 displays the results.

Parental acceptance moderated the relationships between depression and internalized homonegativity and rejection sensitivity, but not the relationship between discrimination and depressive symptoms. Both the complete model and the interaction term were significant in terms of the relationship between internalized homonegativity and depressed symptoms. By examining the relationships between the predictor and outcome variables at 1 SD above and below the mean of the moderator variable, the significant interaction was decomposed in accordance with Aiken and West's (1991) suggestions. Internalized homonegativity was substantially linked to depressed symptoms for those who reported less accepting parental views ($\beta = .18, p = .002$), but not for those who reported more accepting parental attitudes ($\beta = -.06, p = .66$).

Both the entire model and the interaction term were significant in terms of the relationship between rejection sensitivity and depressed symptoms. Rejection sensitivity was significantly linked to depressed symptoms for those who reported less accepting parental attitudes ($\beta = 0.25, p < .001$), but not for those who reported more accepting parental attitudes ($\beta = 0.06, p = .60$). Overall, it appears that parental acceptance may shield people from depressive symptoms when minority stress is present because rejection sensitivity and internalized homonegativity were linked to depressive symptoms for those who reported less accepting parental attitudes but not for those who reported more accepting attitudes.

Self-Esteem as a Moderator

Following the same steps as in the family acceptance moderator analyses, three hierarchical regression analyses were conducted (one for each dimension of minority stress) to examine whether self-esteem moderated the associations between the minority stress dimensions and depressive symptoms. Self-esteem did not moderate any of the correlations between the measures of minority stress and depressive symptoms, in contrast to the findings for the parental acceptance moderator (see Table 2 for results).

Table 1: Table 1: Zero-order correlations of the study's variables using Pearson Product-Moment Correlations

	1	2	3	4	5	6	7	Mean	Std. D
1. Discrimination	-	-	-	-	-	-	-	15.00	02.76
2. Rejection sensitivity	.357**	-						01.40	0.78
3. Internal homonegativity	.083	.051	-					01.97	0.19
4. Depressive symptoms	-.027	.084	.077	-				33.32	13.69
5. Parental acceptance	.171	.180	.061	.135	-			46.39	03.69
6. Self-esteem	.160	.074	.146	.360**	.598*	-		46.82	06.88

*. Correlation is significant at the 0.05 level (2-tailed).

Sexual minority stress significantly predicts psychological distress. Adding family acceptance and self-esteem reduces distress, indicating main effects. Interaction terms are significant, confirming moderation: higher family acceptance and self-esteem buffer the effect of sexual minority stress on psychological distress.

Table 2: Hierarchical Regression Analyses Predicting Depressive Symptoms

ΔR^2	F	Regression analyses	b	B	T	R2
.48	7.22**	Analysis 1: Parental acceptance and internalized homonegativity.				.17
		Parental acceptance	.20	.56	5.22**	
		Internalized homonegativity	.25	.37	6.24**	
		Parental Acceptance x Internalized Homonegativity	.17	.86	3.98**	
.74	4.22**	Analysis 2: Parental acceptance and rejection sensitivity				.22
		Parental acceptance	.15	.56	8.66**	

	Rejection sensitivity	.35	.42	0.22**	
	Parental Acceptance v Rejection Sensitivity	.30	.53	8.84**	
.43	Analysis 3: Parental acceptance and discrimination				.24
	6.22**				
	Parental acceptance	.32	.47	9.63**	
	Discrimination	.34	.74	5.53**	
	Parental Acceptance x Discrimination	.42	.86	7.52**	
.75	Analysis 4: Self-esteem and internalized homonegativity				.36
	5.43**				
	Self-esteem	.36	.51	6.44 **	
	Internalized homonegativity	.42	.55	3.63**	
	Self-esteem X Internalized Homonegativity.	.45	.42	5.95**	
.71	Analysis 5: Self-esteem and rejection sensitivity.				.38
	4.22**				
	Self-esteem	.29	.34	4.77**	
	Rejection sensitivity.	.28	.33	4.22**	
	Self-esteem X Rejection Sensitivity.	.17	.42	6.13**	
.68	Analysis 6: Self-esteem and discrimination.				.27
	6.14**				
	Self-esteem	.24	.43	5.23**	
	Discrimination	.36	.35	3.76**	
	Self-esteem X Discrimination.	.43	.36	7.78**	

$p < .05$. ** $p < .01$. *** $p < .001$.

Moderation Analysis

Hierarchical regression results indicated significant moderation effects: Family acceptance moderated the relationship between sexual minority stress and psychological distress ($\beta = -0.23$, $p < 0.01$). High family acceptance weakened the association between sexual minority stress and psychological distress. Self-esteem also moderated this relationship ($\beta = -0.27$, $p < 0.01$). MSM with higher self-esteem exhibited lower psychological distress despite sexual minority stress. The combined moderation of family acceptance and self-esteem explained 22% of the variance in psychological distress beyond sexual minority stress alone ($\Delta R^2 = 0.22$, $p < 0.001$).

The result indicated that MSM with low family acceptance and low self-esteem reported the highest levels of psychological distress, whereas those with high family acceptance and high self-esteem reported the lowest.

DISCUSSION

The results support the minority stress framework, highlighting that sexual minority stress contributes to psychological distress in MSM (Meyer, 2023). Importantly, family acceptance and self-esteem emerged as protective moderators. MSM with supportive families and higher self-esteem demonstrated lower psychological distress, even under high sexual minority stress. Emotional support and validation from family members mitigated negative mental health outcomes, consistent with previous research (Ryan et al., 2020). Family support act as a primary source of resilience by reducing isolation and promoting adaptive coping. High self-esteem buffered against internalised stigma and strengthened coping mechanisms. This aligns with prior studies linking self-worth to reduced vulnerability to stress (Ueno, 2021). The interaction between family acceptance and self-esteem indicates a synergistic effect: supportive families can enhance self-esteem, which in turn strengthens resilience against psychological distress.

According to earlier studies, those who identify as sexual minorities are more likely to experience unfavorable mental health outcomes due to the stress that comes with it (Feinstein et al., 2022; Hatzenbuehler et al., 2020; Mays & Cochran, 2021). By concentrating on family protective variables that can lessen these connections, the current study expanded on previous research. In particular, the degree to which three aspects of minority stress—discrimination, internalised homonegativity, and rejection sensitivity—and depressive symptoms among lesbians and gay men were influenced by parental acceptance of one's sexual orientation and self-esteem was investigated.

Results showed that reduced depression symptoms were linked to both self-esteem and parental approval. This supports earlier studies that have indicated family ties continue to influence well-being throughout adulthood (Holahan et al., 2024) and demonstrates that this is also the case for homosexual men and lesbians. Furthermore, general family support and parental acceptance were linked to less sensitivity to rejection and prejudice, and parental acceptance was linked to less internalized homophobia. Given the established link between internalized homophobia and depressive symptoms (Newcomb & Mustanski, 2020), which was also noted in the current study, it is interesting that broad family acceptance was linked to fewer depressed symptoms but not internalised

homophobia. This suggests that a supportive family may have the potential to improve well-being, even if it doesn't influence one's feelings about one's sexual orientation.

Mental health practitioners may come across clients whose family are supportive in various ways but may not accept their sexual orientation. For example, a client who typically shows warmth and support but whose parents do not understand that they are gay. Given the complexity of their familial dynamics, clients may require assistance in sustaining self-acceptance in these situations. If they don't have a supportive social network outside of their family, this might be very crucial. Regardless of how much their family members embrace their sexual orientation, members of MSM may need to learn how to accept themselves, even though it may be possible to include family members in treatment to boost support.

The results supported the hypotheses by showing that the relationship between internalised homonegativity and depressive symptoms, as well as the relationship between rejection sensitivity and depressive symptoms, was mitigated by parental acceptance of one's sexual minority status. Individuals who reported lower degrees of parental acceptance had higher depressive symptoms in relation to both aspects of minority stress. Parental acceptance may serve as a protective factor against depressive symptoms following these more internal aspects of minority stress, as these relationships were not significant for individuals who reported higher levels of parental acceptance. These results support the idea that parental love and support may help members of MSM reject the stigma attached to their identity by fostering a sense of relational security and self-confidence (Pearson & Wilkinson, 2023).

The findings suggest that parents demonstrating acceptance of their child's sexual minority identification may be especially crucial in providing this love and support. However, there was no moderating effect of parental acceptance on the relationship between depressive symptoms and discrimination. Lesbians and gay men may find that parental support shields them from distress when confronted with their own negative thoughts and feelings regarding their sexual orientation, but not when confronted with overt prejudice. This is a theoretical possibility. Furthermore, there was a correlation between more general family support and parental acceptance of one's sexual orientation; however, their protective functions were distinct. This is consistent with the matching theory of social support, which suggests that support is most beneficial when it is related to the specific domain of stress (Cohen & Wills, 2015). Doty et al., (2020) found support for this theory, demonstrating that sexuality-related support, but not general support, buffered against the negative effects of sexuality-related stress. Further evidence that support must be tied to the stress domain in order to be protective comes from the findings that parental acceptance of one's sexual orientation, but not general family support, buffered against the harmful effects of minority stress.

These findings have significant ramifications for how mental health providers can support parents who might be having a hard time accepting the fact that their child is a member of a sexual minority. In general, parents should be encouraged to support their children, but it might be especially crucial for parents to let their sexual minority child know that they embrace their sexual orientation.

Parental acceptance of one's sexual minority status may also serve as a protective barrier against the detrimental impacts of more internal aspects of minority stress, even though self-esteem and parental acceptance may both have a good impact on well-being. Given the growing body of research showing that domain-specific support is especially helpful for wellbeing (Doty et al., 2020), parents might be urged to think about how they might support their child who is a sexual minority in relation to the stress that their minority status may create.

LIMITATIONS

A number of limitations should be considered when evaluating these findings. First, because the data are cross-sectional and self-reports, it is not possible to examine the directionality of the correlations. There may be reciprocal relationships between minority stress and depressive symptoms. Considering the strong theoretical and empirical foundation for minority stress as a predictor of depression, as well as the desire to understand protective factors associated with minority stress and depression, it was determined to concentrate on depressive symptoms as the outcome, given that bidirectionality could not be tested using cross-sectional data. To better understand temporal order, longitudinal designs will be crucial for future research. Second, a convenience sample of self-identified lesbians and gay men was recruited, resulting in limited racial/ethnic diversity,

In addition, individuals without computer access could not participate because recruitment and data collection occurred online. However, online methods facilitate access to less visible populations such as sexual minorities (Riggle et al, 2025), and individuals may be more honest about sensitive topics such as discrimination when assessed online (Frankel & Siang, 2019). Since people who do not identify as White and those who identify with another minority sexual orientation may have different family experiences, future research could replicate these findings in more diverse samples and test variables like race/ethnicity, socioeconomic status, and sexual identity as potential moderators of the associations tested in the current study.

RECOMMENDATIONS

Programs that educate families on the importance of acceptance can improve mental health outcomes for sexual minority members. Counselling, therapy, and peer support groups can also help MSM develop resilience and positive self-perceptions. In addition, policies promoting inclusive environments in schools, workplaces, and healthcare settings can reduce stigma and foster both family and self-support. By addressing these protective factors, interventions can mitigate the psychological distress experienced by MSM and promote healthier, more resilient communities. In terms of clinical interventions, mental health programs for MSM should involve family-based support strategies and self-esteem enhancement techniques. Promoting inclusive social environments reduces stigma and fosters both family acceptance and individual resilience.

CONCLUSION

Psychological distress among men who have sex with men is a significant public health concern influenced by sexual minority status. However, family acceptance and self-esteem play crucial moderating roles, buffering the negative impact of stigma and discrimination. Family acceptance provides emotional support and affirmation, while self-esteem fosters resilience and coping efficacy. Recognizing and promoting these protective factors is essential for designing effective interventions and improving the mental health outcomes of MSM populations.

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